STATE OF IOWA

CHESTER J. CULVER, GOVERNOR
PATTY JUDGE, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
EUGENE I. GESSOW, DIRECTOR

March 27, 2009

GENERAL LETTER NO. 8-F-66

ISSUED BY: Bureau of Medical Supports,
Division of Financial, Health and Work Supports

SUBJECT: Employees' Manual, Title 8, Chapter F, ***COVERAGE GROUPS***, pages 16, 22a, 22e, 22f, 24a, 24b, 41, 42, 63, 72j, 112, 115, 116, 117, and 133, revised.

Summary

This chapter is revised to:

- Update the 2009 poverty-level increase for Medicaid.
- Clarify that verification of citizenship and identity is not required if a child is born to a Medicaid-eligible woman.
- Clarify that an applicant or member who provides a signed release to a specific individual or organization for specific information has met the requirements for supplying requested information or verification.
- Correct language and form names and numbers to correspond to current usage.

Effective Date

April 1, 2009

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter F, and destroy them:

Page	Date
16, 22a	September 21, 2007
22e	February 3, 2006
22f	March 7, 2008
24a, 24b	December 24, 2004
41, 42, 63, 72j	March 7, 2008
112	December 21, 2007
115	June 13, 2008
116	March 7, 2008
117	June 13, 2008
133	January 2, 2009

Additional Information

Refer questions about this general letter to your area income maintenance administrator.

Newborn Children of Medicaid-Eligible Mothers

Legal reference: 42 CFR 435.117, 441 IAC 75.1(20); Public Law 111-3

Medicaid is available to newborn children if:

- The mother establishes Medicaid eligibility for the month of the child's birth under an FMAP-related or SSI-related coverage group, including three-day emergency services; and
- The baby lives with the mother.

The mother can establish eligibility before the birth or retroactively, after the birth. An application is not required to add the newborn child to Medicaid.

Add the newborn to the Medicaid case no later than ten days after the birth is reported to the local office. Do not delay adding the newborn for Medicaid even if there is a delay adding the child for other programs.

The newborn is not required to have a social security number in order to be added to Medicaid. This verification is required when the child is no longer eligible as a newborn. See 8-C, SOCIAL SECURITY NUMBER.

The newborn is not required to verify citizenship and identity, because children born to Medicaid-eligible mothers are permanently exempt from verifying citizenship and identity. See 8-C, Verifying Citizenship and Identity.

Note: If the mother receives SSI, do not add the newborn to the mother's SSI case. Add the newborn to an existing FMAP-related case or open a new MAC case for the newborn.

1. Household composition: Mr. K, aged 30, Mrs. K, aged 25 and pregnant, and Child K, aged 2. Mr. and Mrs. K have no income and receive Medicaid under FMAP.

   On July 20, the hospital informs the local office that Mrs. K gave birth to her baby on July 18. Policy requires that the baby be added to the eligible group. The day the birth of the child is reported becomes the application date. Add the baby to the existing Medicaid case immediately, effective July 1.

2. Ms. T, age 19, is pregnant and receives Medicaid under the CMAP coverage group. On May 2, she reports to the local office that her baby was born in April.

Newborn status ends if the mother would not be eligible for Medicaid if still pregnant or if Medicaid has ended (e.g., due to cancellation or the end of a certification period). An application is not required for the automatic redetermination.

Reinstatements before an anticipated effective date of cancellation do not cause a break in the mother's continuous eligibility, so a new application is not required.

Issue timely notice when the newborn loses eligibility due to the mother's ineligibility, using reason code 816 (____ is no longer eligible for Medical Assistance because the mother is no longer eligible and would not be eligible if she were still pregnant).

When the Child Reaches Age One

Legal reference: 441 IAC 75.1(20)

A child who has remained eligible because of newborn status during the first year must be found eligible for Medicaid under another coverage group to continue Medicaid eligibility past the child's first birthday.

Complete an automatic redetermination of eligibility under other Medicaid coverage groups before the child's first birthday. An application is not required to determine eligibility under a coverage group even when the newborn is the only person in the household on Medicaid. However, you may need more information to determine under which coverage group the child is eligible (i.e., social security number).

If the child's first birthday falls on the first day of the month, eligibility ends on the last day of the previous month. If the child's first birthday falls on any day other than the first of the month, eligibility ends on the last day of the birth month.

If additional information is needed in order to complete a redetermination, request this information in writing in the month before the first birthday (if the birthday falls on the first day of the month) or in the month of the first birthday (if the birthday falls on any other day of the month). This allows enough time to complete the redetermination before newborn status is lost.

1. Ms. K, aged 17, receives Medicaid under CMAP. Her child is eligible for Medicaid as a newborn child of a Medicaid-eligible mother. This child turns one on June 4. In June, the worker completes an automatic redetermination and requests needed information, in writing. Eligibility continues, and Ms. K and her child become an FMAP eligible group effective July 1.

A woman who is covered under group or private health insurance is **not** eligible for IFPN unless she can claim good cause due to confidentiality. A woman can claim good cause for not cooperating in filing a claim for health insurance if she is fearful of the consequences.

1. Ms. M, age 17, lives with her parents. She does not want her parents to know she is seeking family planning services. She can claim good cause.

2. Ms. J is married and her husband has health insurance. Her husband does not want her receiving family planning services. Ms. J can claim good cause.

3. Ms. S lives by herself and has health insurance. She cannot claim good cause and is not eligible for IFPN.

Note: Do not complete form 470-2826, *Insurance Questionnaire*, when a woman has insurance but can claim good cause for confidentiality.

Household Size

Legal reference: 441 IAC 75.1(41)"c"(1)

The household size includes the following people living together who are not receiving Supplemental Security Income:

- The woman who is applying for or receiving IFPN benefits,
- Her spouse, and
- Her dependent children.

A mandatory household member cannot be excluded.

1. Ms. M, age 17, lives with her parents. She has no spouse and no children. Her household size is one.

2. Ms. S, age 17, has a one-year-old child and lives with her parents. Her household size is two.

3. Ms. F, age 43, lives with her spouse who receives SSI. Her household size is one.

4. Ms. H, age 36, lives with her spouse and two children, ages 5 and 8. One child receives SSI. Her household size is three.

Income

Legal reference: 441 IAC 75.1(41)"c"

When determining eligibility for IFPN, the household's countable monthly income shall not exceed the amounts shown in the chart below for a household of the same size.

Iowa Family Planning Network Monthly Income Limits: 200% of Poverty								
HH Size	1	2	3	4	5	6	7	Additional
Limit	$1,805	$2,429	$3,052	$3,675	$4,299	$4,922	$5,545	$624 each

Note: The income limit does not apply if a woman qualifies because she was receiving Medicaid when her pregnancy ended.

The gross income (before taxes and other deductions) received by any person included in the household size must be counted.

- Income received by a parent for a teen (e.g. child support, social security benefits) is not counted for the teen's eligibility unless the parent makes it available to the teen.
- Earned income of a dependent child, regardless of school attendance, is counted for the parent's eligibility.

Proof of income shall be documented in the case record. Proof may include copies of pay stubs, an employer's statement, an award letter, an income tax return, etc.

Countable Income

Legal reference: 441 IAC 75.1(41)"c"

Count only the following income in determining IFPN eligibility:

- Money, wages or salary: Count wages according to 8-E, TYPES OF FMAP-RELATED INCOME. Lump-sum income received due to employment is not counted. Project income according to 8-E, Budgeting for FMAP-Related Households.
- Self-employment: Calculate countable self-employment income according to policies at 8-E, FMAP-RELATED SELF-EMPLOYMENT INCOME.

Responsibilities of the Screening Program

The Breast and Cervical Cancer Early Detection Program (BCCEDP) is responsible for determining that the woman:

- Is in need of treatment for cancerous or precancerous condition of the breast or cervix.
- Is under age 65.
- Meets income guidelines.
- Does not have creditable health insurance coverage, except when the woman:
  - Has exhausted her lifetime benefits for breast or cervical cancer treatment, or
  - Has an exclusion clause in her health insurance coverage for breast or cervical cancer treatment.

"Creditable coverage" is defined in the Health Insurance Portability and Accountability Act. Most health insurance is considered creditable coverage, including insurance that has limits on benefits or high deductibles. For the purposes of this coverage group, the Indian Health Services available to Native American women is **not** creditable coverage.

A woman who has been screened and diagnosed through the BCCEDP and is in need of treatment will be referred to DHS to apply for Medicaid.

- The woman will be instructed to present the Department of Public Health's form, *Medicaid Treatment Option Eligibility Verification*, to the DHS office.
- The woman will usually complete a *Health Services Application*, form 470-2927 or 470-2927(S), at the program office. The program will attach the proof of screening form to the application.

However, if you are aware that a woman is eligible but the *Medicaid Treatment Option Eligibility Verification* form is not attached to the application, either:

- Make a written request for the woman to obtain it and provide it to you, or
- Ask the woman to sign a specific release if needed so you can request verification from the program.

If the BCCEDP is a qualified provider, the provider may also determine presumptive Medicaid eligibility for the BCCT coverage group. For requirements to be a presumptive eligibility provider, see 8-M, Qualified Providers for Presumptive Eligibility for BCCT.

Referrals to a BCCEDP

Only BCCEDP staff or a trained designee can determine if a woman is eligible for the BCCEDP (screening services) or for referral for Medicaid under BCCT.

If a woman with a breast or cervical condition contacts DHS and someone other than the woman paid for a mammogram to be done, but she has no verification form from BCCEDP and is not eligible for a mandatory Medicaid coverage group, you may refer her to the nearest BCCEDP. Referrals to a local BCCEDP may be made for:

- Breast and cervical cancer screening services
- The *Medicaid Treatment Option Eligibility Verification* form

Call 1-800-369-2229 or 1-515-242-6200 to identify the nearest program and contact information. Do not suggest that the woman is eligible or make any determination. Simply refer her by saying, "There is a program I suggest you call. Their staff should be able to determine if you are eligible for any services or assistance."

Referrals When Screening Was Paid Through Komen Funds

Women who had breast screening or diagnostic testing paid with funds from the Susan G. Komen Foundation are eligible for BCCT coverage. It is important to determine if a woman may be eligible because Komen funds paid for those services.

If a woman is not sure if Komen funds paid for her screening or diagnosis, ask her to:

- Provide verification from the medical provider's billing office; or
- Sign a specific release of information if needed so you can contact the provider.

If a local BCCEDP and the woman are unable to verify eligibility, contact the BCCT policy specialist via e-mail with the following information:

- Applicant's name, state identification number, and case number.
- Applicant's phone number. (Indicate if only messages can be left at this number.)
- Name, county, and worker number of the IM worker processing the application.
- Name of the health care provider making the cancer diagnosis (either the name of the clinic or the practice, if different from the health care provider name).

Cancel Medicaid if countable income is more than 185% of the federal poverty level for a family of the same size. Consider only people in the transitional Medicaid group for this comparison. Do not divert income to meet the needs of ineligible people or for adult care expenses.

The ABC system calculates continuing transitional Medicaid eligibility when entries are made timely. However, if eligibility must be calculated manually, the formula to determine the average amount of countable earned income to compare to 185% of poverty is:

(Total quarterly gross earned income of eligible group - Total quarterly actual child care paid) / 3	=	Countable average monthly income to compare to 185% of poverty

Transitional Medicaid Monthly Income Limit: 185% of Poverty								
HH Size	1	2	3	4	5	6	7	8
Limit	$1,670	$2,247	$2,823	$3,400	$3,976	$4,553	$5,130	$5,706
For each additional person, add $577.								

Consider only earned income of people who are included in the transitional Medicaid eligible group according to FMAP policy. This includes people who are "considered" people.

Do not use the income of a stepparent who is not a part of the transitional Medicaid eligible group.

Good Cause for Failing to Meet Reporting or Earnings Requirements

Legal reference: 441 IAC 75.1(31)"i"(1)

The household can establish good cause for not returning form 470-2663, 470-2663(S), 470-2663(M), or 470-2663(MS), *Transitional Medicaid Notice of Decision/Quarterly Income Report*, by the due date when the household verifies that at least one of the following conditions exists:

- There was a serious illness or death of someone in the member's family.
- There was a family emergency or household disaster, such as a fire, flood, or tornado.
- There were other reasons beyond the member's control for not returning the report.
- The household did not receive the form for a reason that was not the member's fault. Lack of a forwarding address is considered to be the member's fault.

The household can establish good cause for not having earned income when the household verifies that the lack of earnings was due to:

- An involuntary loss of employment, **or**
- An illness, **or**
- Other circumstances that negatively affect the person's ability to work.

Allow good cause for the first month of a period of proration of a nonrecurring lump sum when there was unearned income in the month. Unearned income is not used in calculating transitional Medicaid eligibility.

The household must verify good cause before the first day of the month after the report month.

If circumstances beyond the control of the household make it difficult for household members to get documentation, grant additional time. However, do not continue transitional Medicaid past the first day after the report month pending substantiation of a good cause claim.

MAC Income Limits

Legal reference: 441 IAC 75.1(28)"a"

When determining initial and ongoing eligibility for MAC, the income limits are:

- 200% of the federal poverty level for pregnant women and infants.
- 133% of the federal poverty level for children ages 1 through 18.

	Monthly Income Limit	
Household Size	Children 1 through 18: 133% of Poverty	Pregnant Women and Infants: 200% of Poverty
1	$1,201	$1,805
2	$1,615	$2,429
3	$2,030	$3,052
4	$2,444	$3,675
5	$2,859	$4,299
6	$3,273	$4,922
7	$3,688	$5,545
8	$4,102	$6,169
Add for each additional:	$415	$624

Complete an automatic redetermination whenever the net countable income exceeds the established limits under the MAC coverage group.

When there are people on the same case who are Medicaid eligible or "considered" at 133% of poverty and 200% of poverty, the *Notice of Decision* will show only the 133% calculation. However, the system does do a calculation for 200% of poverty for eligibility purposes.

The following sections explain procedures for:

- MAC income requirements
- Determining countable income
- Receipt of a lump sum

The following examples are people who aged out of foster care on or after May 1, 2006:

1. Ms. M, age 18, returned to live with her parents. She has no spouse and no children. Her household size is one.

2. Ms. S, age 19, has a child age one, and they return to live with her parents. Ms. S is not eligible for Medicaid with her child. Her child receives Medicaid under another coverage group. The household size for Ms. S is one.

3. Mrs. F, age 19, lives with her spouse who receives SSI. Her household size is one.

4. Mrs. H, age 19, lives with her spouse and two children, ages 5 months and 2. One child receives SSI; the other child receives MAC. Her household size is two.

5. Mrs. K, age 20, lives with her spouse and his child, age 5. The spouse and child do not receive Medicaid. The MIYA household size is three.

MIYA Income Limits

Legal reference: 441 IAC 75.1(42)"d"

When determining initial and ongoing eligibility for MIYA, countable income must be less than 200% of the federal poverty level.

MIYA Monthly Income Limits: 200% of Poverty									
HH Size	1	2	3	4	5	6	7	8	Additional:
Limit	$1,805	$2,429	$3,052	$3,675	$4,299	$4,922	$5,545	$6,169	$624 each

At time of application or review determination, when the net countable income exceeds the established limits under the MIYA coverage group, determine eligibility under the Medically Needy program.

The following sections explain procedures for:

- MIYA income requirements
- Determining countable income
- Verification of income
- Change in income

The following sections give more information on requirements for:

- Age
- Disability
- Earned income
- Resources
- Family income limits
- Payment of premiums
- The relationship between MEPD and Medically Needy

Age

Legal reference: 441 IAC 75.1(39)"a"(2)

To qualify for MEPD, the disabled person must be under age 65.

Disability

Legal reference: 441 IAC 75.1(39))"a"(1)

To qualify for MEPD, a person must be disabled based on the medical criteria for SSI disability. This includes:

- People who receive social security disability (SSDI) benefits or receive railroad retirement benefits based on the same disability criteria used by the Social Security Administration.
- People whose SSDI benefits have stopped but are still eligible for Medicare.
- People who are not in those groups but are found to meet the medical criteria for disability through a disability determination completed for the Department by Disability Determination Services (DDS).

  Always check to see if the person is receiving SSDI or railroad retirement benefits or Medicare before initiating a disability determination through DDS. See 8-C, Establishing Disability. Substantial gainful activity is not considered in deciding if a person is disabled for this coverage group.

Earned Income

Legal reference: 441 IAC 75.1(39)"a"(4)

To qualify for MEPD, the applicant must have earned income from employment or self-employment.

Family Income Less Than 250% of Federal Poverty Level

Legal reference: 441 IAC 75.1(39)a.(3)

Use 470-3686, *MEPD Income Worksheet*, to determine if the family monthly income is less than 250% of the federal poverty level. Count the total income of the family. "Family" is defined as follows:

- If the client is under the age of 18 and is unmarried, the "family" includes all of the following who live in the same household as the client:
  - The parents of the client.
  - All siblings under age 18 and unmarried.
  - Any children of the client.
- If the client is aged 18 or older or is married, the "family" includes all of the following who live in the same household as the client:
  - The client's spouse.
  - Unmarried children of the client or the client's spouse who are under age 18.

Allow all disregards and exemptions that are allowed for other SSI-related Medicaid coverage groups, including the $20 dollar general income deduction, the $65 work exclusion, and 50% remainder deduction from earned income.

- Total the unearned income of all family members and allow one $20 general income deduction.
- Total the earned income of all family members and allow the $65 work exclusion and 50% remainder deduction from the total income.
- Add the net unearned income and net earned income and compare the sum to 250% of the federal poverty level for the family size.

MEPD Monthly Income Limits: 250% of Poverty									
HH Size	1	2	3	4	5	6	7	8	Additional:
Limit	$2,257	$3,036	$3,815	$4,594	$5,373	$6,153	$6,932	$7,711	$780 each

Mr. F lives with his wife and their three children, who are all unmarried and under age 18. The household size is five. Mr. F has $600 in social security disability income and earned income of $600 per month. Mrs. F has $1,000 in earned income. She and each child receives $100 a month social security due to Mr. F's disability.

To calculate income for the 250% test, add all unearned income of the family:

$ 600	For Mr. F
+ 100	For Mrs. F
+ 300	For children ($100 each child)
$ 1,000	Unearned income
– 20	General income deduction
$ 980	Net countable unearned income

Add all earned income of the family.

$ 600.00	For Mr. F
+ 1,000.00	For Mrs. F
$ 1,600.00	Earned income
– 65.00	Work exclusion
$ 1,535.00	
– 767.50	One half remainder
$ 767.50	Net countable earned income

Add $980 net countable unearned and $767.50 net countable earned income = $1,747.50. As income for the family is less than 250% of the poverty level for five, Mr. F meets income eligibility criteria.

Premiums

Legal reference: 441 IAC 75.1(39)"a"(6)

If the family monthly income is less than 250% of the federal poverty level, determine whether a premium should be assessed. Use form 470-3686, *MEPD Income Worksheet*, to calculate the premium. Count only the gross income of the disabled person to determine the amount of the premium.

The ABC system will assess a premium when the eligible person's gross monthly income is above 150% of the federal poverty level according to the following schedule. When the person's gross income is at or below 150% of poverty, no premium is assessed.

Premium Schedule	
If monthly gross income of the disabled person is above:	**The monthly premium is:**
150% of federal poverty level ($1,354)	$29
180% of federal poverty level ($1,625)	$53
220% of federal poverty level ($1,986)	$80
240% of federal poverty level ($2,166)	$110
262% of federal poverty level ($2,365)	$140
318% of federal poverty level ($2,870)	$170
342% of federal poverty level ($3,087)	$200
390% of federal poverty level ($3,520)	$230
425% of federal poverty level ($3,836)	$260
460% of federal poverty level ($4,152)	$291
500% of federal poverty level ($4,513)	$323
548% of federal poverty level ($4,946)	$354
607% of federal poverty level ($5,479)	$392
666% of federal poverty level ($6,011)	$430
725% of federal poverty level ($6,544)	$471
824% of federal poverty level ($7,437)	$535

Household Size	300% of Poverty	Household Size	300% of Poverty
1	2,708	5	6,448
2	3,643	6	7,383
3	4,578	7	8,318
4	5,513	8	9,253

If the family size is over 8, add $935 for each additional member.

Health Insurance Enrollment

Legal Reference 441 IAC 75.1(43)

Parents living with the child must enroll the child in their employer's group health insurance plan when the employer pays at least half of the annual premium cost to cover the child. Notify the parents about their responsibility for health insurance enrollment by giving them Comm. 337, *Medicaid for Kids with Special Needs*.

If the child is already enrolled in the parent's employer group insurance:

- The parents must provide verification of the enrollment.
- The child should not be disenrolled unless the parents provide proof that the employer paid **less** than 50% of the cost of the annual premiums.

If the child is not enrolled in the parent's employer's group insurance:

- Request the health insurance cost information when requesting other verifications from the parent.
- Check the information to see if the employer pays at least half the annual cost of the premiums.
- If the employer pays at least half the cost, then tell the parent:
  - If the child can enroll without a waiting period, then the parent must provide verification of the child's enrollment before Medicaid can be approved.
  - If they verify that they need to wait to enroll the child at a later date, such as during the open enrollment period, Medicaid can be approved since the employer insurance is not available to the child until a later date.